State of Tennessee
Department of Health

TENNESSEE BOARD OF CHIROPRACTIC EXAMINERS

227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243

(Toll Free In State) 1-800-778-4123
Local Nashville Area 615-532-5138
www.tennessee.gov

Application and Procedures for Licensure

Chiropractic X-Ray Technologist

STATE OF TENNESSEE
DEPARTMENT OF HEALTH
HEALTH RELATED BOARDS
227 French Landing, Suite 300
Heritage Place Metro Center
NASHVILLE, TENNESSEE 37243

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APPLICATION INSTRUCTIONS FOR EXAMINATION/CERTIFICATION AS A CHIROPRACTIC X-RAY/TECHNOLOGIST

APPLICATION CHECK SHEET

Provided below is a checklist for your personal use and convenience containing all the things you must do to receive consideration for examination or certification. **NOTE: All submissions must be executed and dated less than one (1) year before receipt or they will be rejected by the Board.**

All applicants must complete items 1 through 5.

		DONE
1.	Complete, sign, have notarized and mail the application pages 1 through 5.	_____
2.	Attach to your application in the space provided a clear, recognizable, recent photograph of yourself. You must sign the back of the photograph.	_____
3.	Submit with the application a certified birth certificate or other equivalent document.	_____
4.	Submit with your application a notarized copy of your high school diploma or notarized copy of your GED certificate.	_____
5.	Submit one (1) original letter of recommendation from a health care professional on the signatory's letterhead attesting to your good moral character.	_____

		DONE
1.	Submit a copy of your certificate of completion of a minimum combined total of 48 classroom hours approved by the board, including such subject material as radiation protection, radiation physics, radiographic techniques, patient care and positioning, equipment maintenance, radiographic anatomy and physiology, x-ray quality control, and instruction on Tennessee Law and Rules pertaining to the Chiropractic X-Ray Technologist.	_____
2.	If you hold or have ever held a license/certificate as an X-Ray operator in another state complete and mail Attachment 1 to each State. Please follow directions on Attachment 1.	_____
3.	Submit with your application a check or money order in the amount of $190.00 made payable to the Board of Chiropractic Examiners. This is a NON-REFUNDABLE FEE.	_____

If you are applying by CRITERIA RECIPROCITY/ENDORSEMENT in additions to items 1 through 5 on page one of the instructions, the following items are required.

DONE

1. An applicant requesting certification by criteria (reciprocity) must be currently licensed or certified in another state as a Chiropractic X-Ray Technologist. Complete and mail Attachment 1 to the State in which you are currently licensed. _____

   OR

   Be certified from either the American Chiropractic Registry of Radiological Technologists or the American Registry of Radiological Technologists. _____

   * If license is not current, applicant must conform to Rule 0260-3-.04(2)(b)

2. If you hold or have ever held a license/certificate as an X-Ray Operator in another State (other than above) complete and mail Attachment 1 to each State. _____

3. Submit with your application a check or money order in the amount of $370.00 made payable to the Board of Chiropractic Examiners. THIS IS A NON REFUNDABLE FEE. _____

UNDERSTANDING THE APPLICATION PROCESS

If an address change occurs at any time, you must notify the Board Office in writing immediately.

1. **ALL FEES ARE NON-REFUNDABLE.**

2. All documents and fees required to be submitted by you or which must be requested from the appropriate institutions in this application process, must be mailed directly to:

Board of Chiropractic Examiners **227 French Landing, Suite 300** **Heritage Place Metro Center** **Nashville, TN 37243**	**For Federal Express or Special Courier:** **Board of Chiropractic Examiners** **227 French Landing, Suite 300** **Heritage Place Metro Center** **Nashville, TN 37243**

3. Allow fourteen (14) working days for information mailed to our office to be received and placed in your file. Federal Express or special courier services will not appreciably reduce the processing time. Additionally, if Federal Express or special courier services are used you will be responsible for charges incurred. The Board asks that you please give the Board Office every consideration in this matter.

4. **We will discuss application status with the applicant or applicant's spouse only**. Please inform hospitals, employers, recruiters, referral companies or insurance companies that application status updates must be obtained from you.

5. If necessary documentation has not been received when your application has been received by the Board Office, an initial deficiency letter will be sent to you by certified mail. The supporting documentation requested in the letter must be received in the Board Office thirty (30) days from the date of the initial deficiency letter. Files not completed in a timely manner will be closed.

PLACE FULL FACE, PASSPORT SIZE PHOTOGRAPH HERE

For Office Use Only

Proficiency:		
Application	1145-001	$ 180.00
State Reg.	1145-006	$ 10.00
Total		$ 190.00
Criteria/Reciprocity:		
Application	1145-001	$ 80.00
Certificate	1145-001	$180.00
Reciprocity	1145-001	$100.00
State Reg.	1145-006	$ 10.00
Total		$370.00

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TENNESSEE BOARD OF CHIROPRACTIC EXAMINERS

APPLICATION FOR REGISTRATION AS A CHIROPRACTIC TECHNOLOGIST

Please indicate method of application.

____ (1) ARRT Examination for Limited Scope

(CRITERIA RECIPROCITY/ENDORSEMENT)

____ (1) Certification from the American Chiropractic Registry of Radiologic Technologists or the American Registry of Radiological Technologists (copy of certification must be attached)

____ (2) Currently licensed/certified in another State as a Chiropractic X-Ray Technologist.

____ (3) Inactive license/certificate in another State as a Chiropractic X-Ray Technologist.

Name _____
(Last) (First) (Middle) (Maiden)

Date of Birth _____ Social Security # _____
(Month) (Day) (Year)

Current Home Mailing Address

_____
_____
_____

Current Practice Address

_____
_____
_____

Home Phone (____) _____

Work Phone (____) _____

EDUCATION

Have you received your high school diploma? _____ Yes _____ No

If the answer above is No, have you obtained your GED? _____ Yes _____ No

Name of High School	City, State	Date of Graduation

Date you obtained your GED _____

LICENSURE AND CERTIFICATION INFORMATION

List below all states, countries or provinces in which you have ever been or currently are licensed permitted or certified as a Chiropractic X-Ray Technologist. Additional pages may be added if necessary. Submit a copy of **Attachment 1** to all such states, countries, or provinces regarding such licensure, certification or permit.

STATE	LICENSE NUMBER	DATE ISSUED	CURRENT STATUS

COMPETENCY INFORMATION

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers to the questions in this part are in the **affirmative,** attach an explanation on a separate sheet. ***In support of your explanation, the final documents or orders from the issuing states, courts, or agencies must be submitted along with this application*.**

For the purposes of these questions, the following phrases or words have the following meanings:

1. **"Ability to practice your profession"** is to be construed to include all of the following:

   a. The cognitive capacity to exercise reasoned professional judgments and to learn and keep abreast of developments in your profession; and

   b. The ability to communicate those judgments and information to patients and other health care providers, with or without the use of aids or devises, such as voice amplifiers; and

   c. The physical capability to perform tasks and procedures required of your profession, with or without the use of aids or devices, such as corrective lenses or hearing aids.

2. **"Medical Condition"** includes physiological, mental or psychological conditions or disorders, such as, but not limited to; orthopaedic, visual, speech and/or hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

3. **"Chemical substances"** is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

4. **"Currently"** does not mean on the day of, or even in the weeks or months preceding the completion of this application. Rather it means recently enough so that the use of drugs or alcohol may have an ongoing impact on one's functioning as a licensee, or within the past two (2) years.

5. **"Illegal use of controlled substances"** means the use of controlled substances obtained illegally (e.g. heroin, or cocaine) as well as the use of controlled substances which are not obtained pursuant to a valid prescription or not taken in accordance with the directions of a licensed health care practitioner.

QUESTIONS:	**YES**	**NO**
1. Do you currently have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety?	_____	_____
a. If yes, are they reduced or ameliorated because you receive ongoing treatment (with or without medication) or participate in a monitoring program?	_____	_____
b. If you have any limitations or impairments caused by an existing medical condition, are they reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice?	_____	_____

[If you receive such ongoing treatment or participate in such a monitoring program, the Board will make an individual assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition so as to determine whether an unrestricted license should be issued, whether conditions should be imposed or whether you are not eligible for licensure.]

COMPETENCY INFORMATION continued

QUESTIONS:	YES	NO
2. Do you currently use chemical substances?		
If yes, do they in any way impair or limit your ability to practice your profession with reasonable skill and safety?		
3. Are you currently engaged in the illegal use of controlled substances?		
If yes, are you currently participating in a supervised rehabilitation program or professional assistance program that monitors you in order to assure that you are not engaged in the illegal use of controlled substances?		
4. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism or voyeurism?		
5. If you have ever held or applied for a license or certificate as an X-Ray operator in any state, country or province, has it been or was it ever denied, reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action?		
6. Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?		
7. In relation to the performance of your professional services in any profession:		
Have you ever had a final judgment rendered against you; or		
Have you ever had settlement of any legal action rendered against you; or		
Are there any legal actions pending against you or to which you are a party?		
8. If you have ever held a license or certificate in any health care profession, has it ever been reprimanded, suspended, restricted, revoked, or otherwise disciplined, curtailed or voluntarily surrendered under threat of investigation or disciplinary action?		

APPLICANT: FILL OUT THE FOLLOWING AFFIDAVIT IN THE PRESENCE OF A NOTARY PUBLIC
AFFIDAVIT AND RELEASE

I, _____, of _____,
(Applicant's Name) *(City)* *(State)*
being duly sworn and identified as the person referred to in this application, attests to the truth of each statement made in said application. I further swear that I have read and understand the law and the rules and regulations which were enclosed in the application packet and agree to abide by them in the practice of my profession in the State of Tennessee.

I HEREBY:

SIGNIFY my willingness to appear to answer such questions as the Board may find necessary which may include an interview.

RELEASE to the Board, its staff and their representatives, any and all documentation necessary now and in the future to establish my physical and mental capabilities to safely practice my profession.

AUTHORIZE release, use of disclosure of otherwise HIPAA protected health information to the limited extent necessary for my application to receive full consideration up to and including discussion in a public forum should that become necessary.

AUTHORIZE the Board, its staff and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others and any other qualifications;

RELEASE from liability the Board, its staff and all their representatives and any and all organizations which provide information for their acts performed and statements made in good faith and without malice concerning my competence, ethics, character and other qualifications for licensure.

ACKNOWLEDGE that I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical and other qualifications and for resolving any doubts about such qualifications.

THIS CERTIFIES THAT THE INFORMATION SUBMITTED BY ME IN THIS APPLICATION IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

_____ _____
SIGNATURE **DATE**

Sworn to before me, this _____ day of _____, _____.

_____ Affix Seal Here
NOTARY PUBLIC

My Commission expires _____

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CLEARANCE FROM OTHER STATE LICENSURE BOARDS

APPLICANT: Please provide the information requested in the top box and then mail one form to the licensure board in each state where you hold or have ever held a license to practice any profession. (Copies of this form can be used.) **NOTE:** Some states require a fee for providing clearance information. To expedite your application, you may wish to contact the applicable state(s).

To Be Completed By Applicant (Please Print In Ink)

I, the undersigned applicant, was granted a license/certificate to practice _____ with **(check one)**
(Profession)

License ❑ / Certificate ❑ / Registry ❑ number _____ on _____ the State of _____.
(Date)

The Tennessee Board of Chiropractic Examiners requests that I submit evidence of the current status of that license/certification in your state. You are hereby authorized to release any information in your files, favorable or otherwise, directly to the Tennessee Board of Chiropractic Examiners.

_____
Applicant's Signature

Date: _____

_____
Applicant's typed or printed name

To Be Completed By Administrative Office of State Licensure Board

Name In Full As It Appears On License/Certificate or Permit.

_____
(First) (M.I.) (Last)

License/Certificate/Permit Number: _____ Profession: _____

Date Issued: _____

Basis of issuance: _____ Endorsement/Reciprocity with _____
(Check One) (State)

_____ Written Examination _____
(Name of Exam)

The License is currently active and registered? Yes _____ No _____
Is there any derogatory information on file? Yes _____ No _____

_____ _____ _____
Authorized Signature Title Date

State Board: Please return this form to:

Tennessee Board of Chiropractic Examiners
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, Tennessee 37243

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